In the Supreme Court

Appeal from the Eaton Circuit Court
Hon. Calvin Osterhaven

ADVOCACY ORGANIZATION FOR PATIENTS & PROVIDERS,
a non-profit Michigan corporation, et al.,

Plaintiffs-Appellants,

-vs- Docket No. 124639

AUTO CLUB INSURANCE ASSOCIATION, et al.

Defendants-Appellees.

PLAINTIFFS-APPELLANTS' REPLY BRIEF

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In response to defendants-appellees Auto Club Insurance Association, et al.'s brief on appeal, plaintiffs-appellants Advocacy Organization for Patients and Providers, et al., through their attorneys Sheldon Miller & Associates, respectfully direct this Court's attention to the following points:

1. ***The issue is not whether insurers may review the "reasonableness" of provider charges but how their reviews are carried out.***

Defendants expend a considerable portion of their brief on appeal in arguing a point that is not in dispute. That is, they make the case that no-fault insurers may examine charges for medical services to determine if they are "reasonable." (Defendants' brief, pp 15-22, 35-37, 44-45.)

Plaintiffs never argued that "providers can charge an unreasonable fee." (Defendants' Argument I(B)(3); defendants' brief, p 25). The issue is, and always has been, how "reasonableness" is to be determined.

2. ***Defendants' have not complied with this Court's directive to "explain in detail the computations they use in determining whether a particular charge meets the*** 80th ***percentile test."***

This Court granted plaintiffs' application for leave to appeal on June 25, 2004. (Appendix, pp 73a-74a.) The order specifically provided, "[W]e DIRECT defendants to explain in detail the computations they use in determining whether a particular charge meets the '80th percentile test.'" [1] (Appendix, p 73a.) In response, however, defendants resubmitted the same 14 affidavits and one deposition excerpt they attached as exhibits in the Court of Appeals.

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[1] Defendants complain that plaintiffs "spent a great deal of attention on this issue" in their application (Defendants' brief, p 8), when, in fact, plaintiffs' discussion of the "80th percentile" method occupied about one page out of 34. Defendants also claim that, in this Court, plaintiffs "spend the rest of their briefs attacking the straw man they have created." (Defendants' brief, p 35.) Aside from the fact that this Court was obviously interested in the "80th percentile" system, plaintiffs' discussion of the issue consumes approximately 3% of their brief on appeal.

Of the 14 affidavits, eight have nothing to do with the determination of "reasonableness." (Appendix pp 37b-39b; 40b-42b; 114b-115b; 116b-117b; 154b-155b; 156b-157b; 158b-159b and 164-165b.) Twelve of the witnesses were either insurance claim representatives, claims managers or other insurance company employees; two were attorneys. None of the affidavits came directly from an employee of any of the review companies. Rather, five of the witnesses offered a description of their "understanding" of what the review companies do. See Appendix, pp 57b, ¶¶ 8-9 (MedAudit); pp 61b-62b, ¶¶4-5 (ManageAbility and Review Works); pp 109b (Review Works); pp 148b-149b, ¶8 (Review Works)[2]; p 161b, ¶4 (Review Works). Another witness refers to "proprietary medical bill software purchased by Allstate." (Appendix p 113b, ¶4.) Only the claims manager from Citizens Insurance Company actually describes the company's own procedure. (Appendix, p 34b, ¶5.)

Defendants claim that they "have never advocated for a[n] '80th percentile test,' and do not advocate that position here." (Defendants' brief, p 8.) Of the defendants whose review companies are on record, however, seven use Review Works, or at least, used its services at the time this matter was in the trial court: Auto Club Insurance Association (Appendix, p 62b, ¶5); Auto-Owners Insurance Company (Appendix, p 109b, ¶3); Farmers Insurance Exchange (Appendix, p 148b, ¶4); Secura Insurance Company (Appendix, p 155b, ¶5); TIG Insurance Company (Appendix, p 161b, ¶4); Titan Insurance Company (Appendix, p 157b, ¶5); and Wolverine Mutual Insurance Company (Appendix, p 159b, ¶5). Citizens also used an "80th percentile" method. (Appendix, p 34b, ¶5.) In addition, three companies made use of Med Audit, which also employs a "percentile" method. (Appendix, p 57b, ¶¶8-9).

[2] This witness does not explain how the payment is determined, only how the company decides whether the service was necessary.

Defendants rely on an excerpt from the deposition of one of Review Works' employees, Diana Matejo, to explain the company's system for determining provider payments. (Appendix, pp 44b-55b.) [3] This is the same excerpt as defendants submitted in the Court of Appeals, despite Matejo's notably limited ability to articulate Review Works' procedures.

It is apparent, however, that the entire system is based on comparisons of providers' charges to "charges of other providers for the same [current procedural terminology or other standardized] code." (Matejo deposition, p 63; Appendix, p 50b.) They "use the entire state of Michigan for that." (Matejo deposition, p 72; Appendix, p 52b.)

> [W]e can input the code that we want for the time frame that we want it, and it will print out all of the codes that were billed within that time frame underneath that code with all of the fees and the computer does the 80th percentile calculation and how it would do that would be out of 100 providers *it would line them all up*, but it doesn't print them that way. I didn't want you to think that. *And where the 80th one bills is what it determines is the 80th percentile.* [Matejo deposition, pp 63-64; Appendix, p 50b. Emphasis supplied.]

She attempted to explain further:

> Q: . . . [W]hat does the computer program do?
>
> A: It calculates the 80th percentile, but it's probably smarter than people so it doesn't have to print them in order to figure it out.
>
> Q: Well, I guess the 80th percentile is not 80 percent of what the provider charges, is it?
>
> A: No. The 80th percentile is where the 80th provider charged out of however many there are. . . . So if there are 400 providers, the 80th percentile is 320.
>
> Q: . . . . [T]o use your example of 400 providers [who] have charged for this code and you take the 320th, that's the 320th from the lowest on a spectrum to the highest, right?
>
> A: That's correct, but it doesn't print that way.
>
> Q: . . . [S]uppose the 330th provider billed the same as the 320th provider, what would the system evaluate as the reasonable charge?

[3] Several of the affidavits in defendants' appendix paraphrase this description.

A: It would all be the same. The 80th percentile can be the same as the 50th percentile, the 80th percentile can be the same as the 100th percentile. You know, normally you see a normal bell curse, but there certainly are cases in which the percentiles go over a spread. [Matejo deposition, pp 66-68; Appendix, p 51b.]

As plaintiffs noted in earlier briefs, Matejo and Review Works in general misuse the term "percentile." A percentile is "a value on a scale of one hundred that indicates the percent of a distribution that is equal to or below it (a percentile score of 95 is equal to or better than 95 percent of the scores)." Webster's Ninth New Collegiate Dictionary, p 872.

> The percentile rank **of** a score is the percentage of scores in its frequency distribution which are lower. For example, a test score which is greater than 90% of the scores of people taking the test is said to be at the 90th percentile. en.wikipedia.org/wiki/Percentile_rank [9/23/04.]

Unless 100 percent of the scores are the same, then, it is impossible for "the 80th percentile [to] be the same as the 50th percentile" or "the 80th percentile [to] be the same as the 100th percentile." For example, the code for "application of rigid lower leg cast" is 29445. If a sample of providers charge from $100 to $300 for the procedure, it is possible that 50% of them charge $200 or less and 80% of them charge $250 or less, but there is no way that both 50% *and* 80% of them could charge the same amount or less.

What Matejo appears to have been describing, then, is a rank order system. In the example above, if 80% of the providers whose charges were entered in the database for the prior calendar year charged $250 or less, Review Works would apparently call $250 a "reasonable" charge and recommend paying it. If 80% of them charged $101 or less, then $101 would be payable. If 80% of them charged $299, then $299 would be the cut-off point. And so on.

The point is, this system will *always* define 20% of the charges as "too high," no matter how low they are, just as it will define 80% of the charges as "reasonable," no matter how high they are. The fact that allegedly only 7% of the claims are rejected as excessive (Appendix, p

52b) does not mean that the system will not reject 20% of the charges. It only means that no more than 7% of the providers whose bills go through Review Works' analysis are among the 20% whose charges are deemed too high.

Note, too, that Review Works database, at least as described by Matejo, is state-wide.[4] Thus, providers in higher-expense areas (e.g., cities and southeast Michigan) will more often find their charges deemed excessive than those in lower-cost locations (e.g., rural communities and the Upper Peninsula). Defendant insurance companies have considerable discretion to adjust their premiums to reflect geographic variation in claims costs, but plaintiffs providers are constrained by a state-wide comparison when it comes to reimbursement.

More to the point, however, the data indicate that all the insurers and review companies who described their methods use some comparison of providers' fees to other providers' fees. (Defendants' brief, p 9.) As plaintiffs have been saying all along, this is not the appropriate method under the statute.

Providers may charge an amount no greater than what they "customarily charge[] . . . in cases not involving insurance." MCL 500.3157. Defendants' version of "cases not involving insurance" is not limited to no-fault insurance but involves all patients "covered by programs such as Medicare, Medicaid, HMOs, PPOs, etc." (Defendants' brief, p 17, n 21.) What plaintiffs *are paid by* insurers, however, is not what they *charge* "in cases not involving insurance."

A reply brief is not the place to explore this issue, but plaintiffs note that the Court of Appeals rejected such an approach in *Hofmann v ACIA*, 211 Mich App 55; 535 NW2d 529 (1995), when it held that "the relevant inquiry under § 3157 is not the amount that is customarily

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[4] Citizens' system and Med Audit break providers down by zip code. (Appendix p 34b, ¶5; Appendix, p 57b, ¶9.) Med Audit, however, uses the 50th percentile rather than the 80th as its break point. (Appendix, p 57b, ¶9.)

charged to other health insurers, but rather the amount that is customarily charged 'in cases not involving insurance.'" 211 Mich App 107. See also *Johnson v Michigan Mutual Ins Co*, 180 Mich App 314; 446 NW2d 899 (1989), holding that a hospital's charge for a "medically indigent" individual were not limited to what it would have had to accept if his care had been paid for by Medicaid instead of the defendant no-fault insurer.

There is very little information in the record about the numbers that go into the review companies' and insurers' databases. It is impossible, therefore, to determine whether some providers interpret "cases not involving insurance" the same way defendants do. That is, they may *already* be billing no-fault insurers at the same rate they expect to be paid for patients "covered by programs such as Medicare, Medicaid, HMOs, PPOs, etc." Perhaps some charges fall into the 80%-and-under group as a result of a self-imposed limitation on what providers request in motor vehicle accident cases, rather than what providers actually do charge in "cases not involving [no-fault] insurance."

3. *The methods employed by defendants do not control the costs of medical care because, by defendants' own description, providers determine the cost of their services.*

Defendants cite control of medical and insurance costs as a goal of the no-fault act. (Defendants' brief, pp 22-24.) It is apparent, however, that the charge-comparison system defendants actually employ has, in the long run, the opposite effect.

As she was attempting to explain the so-called "80th percentile method," Matejo went on to say:

> [T]he percentile structure really gives the onus back to the providers. You know, they control their own destiny somewhat. They have more control over their destiny than the payor portions of the industry do. [Matejo deposition, pp 68-69; Appendix, pp 51b.]

She elaborated:

> [I]f you look at the pot of how health care is administered in this country, we have the patient, we have the provider, and we have the payor. And *the provider determines what he wants to charge*, and there, you know, with the exception of some workers' comp statutes and Medicare, *they can charge whatever they want.* They could charge a thousand dollars to take out a splinter, that's their right.
>
> And then you have the payor part of the community who has to determine what they're willing to reimburse for that procedure, and that could be in a variety of methods, it could be contractual so that they have to accept it, but *the providers determine their own destiny with percentiles because if they don't think they're making enough money they can just keep raising their charges, and since most reimbursers go back a year for the previous year's data, they can raise their rates annually that way.* [Matejo deposition, pp 69-70; Appendix, pp 51b-52b. Emphasis supplied.]

In other words, a system that defines the "reasonableness" of providers' charges in terms of what their colleagues bill does nothing to control costs.

4. Defendants do use fee schedules and rate tables.

Defendants claim that "there is no support" for the "assertion" that "defendants are using various fee schedules and rate tables for the determination of what is reasonable." (Defendants' brief, p 30, n 27.) What evidence there is in the record, however, does indicate that defendants make use of "fee schedules and rate tables." See Appendix, pp 135a (ManageAbility uses "HIAA (Health Insurance Association of America) tables, various health plan reimbursement schedules such as Blue Cross Blue Shield of Michigan, SelectCare, health Alliance Plan (HAP), and the Michigan Workers' Compensation Fee Schedule"); Appendix, p 116a (Secura Insurance Company indicating that charges are "far in excess of" Blue Cross, Medicare and worker's compensation schedule); Appendix, p 57b (MedAudit uses commercially-published fee reference guides).

5. *The evidence indicates that the private review system developed at the same time as the insurer defendants' attempts to implement legislative limits on provider payments.*

Of the ten insurers whose employees or attorneys stated that they used the service of outside review companies, nine identified a date when these contracts were initiated. Auto Club and Frankenmuth began in 1990 (Appendix, pp 61b, ¶3; 37b, ¶2); Auto-Owners in 1991 (Appendix, p 109b, ¶3); Farm Bureau, Farmers Insurance Exchange and Titan in 1992 (Appendix, pp 56b, ¶5; p 148b, ¶4; p 156b, ¶4); TIG Insurance Company in 1994 (Appendix, p 160b, ¶ 3); and State Farm in 1995 (Appendix, p 41b, ¶6).

The no-fault act "applies to motor vehicle accidents occurring on or after October 1, 1973." MCL 500.3179. Michigan insurers, then, were able to process claims without outside assistance, in accordance with MCL 500.3157, for the better part of twenty years. The outside review system and the insurers' proposal to limit no-fault payments to those under the worker's compensation system, then, developed at the same time.

6. *The federal claims are independent of the issues before the Michigan courts.*

Defendants assert that the Sixth Circuit "reject[ed] the very crux of plaintiffs' case." (Defendants' brief, p 15.) As the Court of Appeals recognized, however, the claims in the federal case were not related to the state court issues.

> Plaintiffs also alleged . . . a federal due-process claim, one count of common-law fraud, and eight counts of . . . RICO . . . violations . . . . The case was temporarily removed to federal district court on federal-question jurisdiction arising out of the RICO claims. The district court dismissed plaintiffs' RICO claims and federal due-process claim, and the United States Court of Appeals for the Sixth Circuit affirmed. . . . As a result, *the case was remanded to the state trial court on the remaining claims, which were based exclusively on Michigan law.* [*AOPP v ACIA*, 257 Mich App 365, 370, n 2; 670 NW2d 569 (2003). Emphasis supplied.]

7. Judge Bell's opinion is not "the law of the case."

Defendants state that Judge Bell's holding that "the review of medical bills by insurers lacked a sufficient close nexus to the state and that the actions by the insurers could be deemed to be state action" is "the law of the case." (Defendants' brief, p 31, n 29.) As this Court, of course, knows, "Under the law of the case doctrine, 'if *an appellate court* has passed on a legal question and remanded the case for further proceedings, *the legal questions* thus determined by the appellate court will not be differently determined *on a subsequent appeal in the same case* where the facts remain materially the same.'" *Grievance Administrator v Lopatin*, 462 Mich 235, 259; 612 NW2d 120 (2000) (emphasis supplied). Judge Bell's opinion, obviously, is not that of "an appellate court," nor was there "a subsequent appeal" on the same issues. The law of the case doctrine, then, is not applicable.

8. Defendants cannot reasonably deny that there were "contracts" between the provider plaintiffs and their patients.

Defendants "do not agree" that there are contracts between the providers and their patients. (Defendants' brief, p 47, n 39.) "An implied contract exists where one engages or accepts beneficial services of another for which compensation is customarily made and naturally anticipated." *Rocco v Michigan Dep't of Mental Health*, 114 Mich App 792, 799; 319 NW2d 674 (1982). The existence of an implied contract to pay for medical services, then, is elementary.

9. Munson *did involve issues of "reasonableness."*

Defendants describe as "plainly wrong" the statement that "[t]he defendant claimed that the hospital's charges were 'unreasonable'" in *Munson Medical Center v Auto Club Ins Ass'n,* 218 Mich App 375; 554 NW2d 49 (1996). (Defendants' brief, p 25, citing plaintiffs' brief, p 21.) The *Munson* opinion, however, clearly states that "ACIA argued that Munson was not entitled to

summary disposition because Munson's motion was unsupported by competent evidence that its charges were reasonable . . ." and "ACIA could [not] accept Munson's charges as reasonable." 218 Mich App 380.

10. Plaintiffs did not "advocate" the "extreme position" ascribed to them.

Defendants state that "Plaintiffs have advocated the extreme position that if their clients want to base their charge for a particular service 'on the number of stars they happen to be able to count in the sky on any given night' they can do so." (Defendants' brief, p 15, citing Appendix, p 138a.) The passage cited should be viewed in context.

Defendants had requested information on how the provider plaintiffs set their charges for individual services. Plaintiffs moved for a protective order. At the hearing, counsel argued:

> [T]he ways that my clients decide what their charges are have absolutely no bearing on the customariness and the reasonableness of that number. For example, if my clients want to base their charge for a particular service on the number of stars they happen to be able to count in the sky on any given night, it may vary. . . .
>
> It is not up to the insurance industry to figure out what those charges should be. And it is not the insurance industry's business how my clients operate their own businesses. [Discovery Protective Order, pp 8-9; Appendix, pp 138a-139a.]

Counsel was simply making the point that how the plaintiff providers developed their fee schedules was not relevant to a determination of whether they billed the defendant insurers the same charges they made in other cases. As noted *supra* and throughout these proceedings, plaintiffs have never maintained that providers are permitted to ask for unreasonable fees. They have asked only that the statutory criterion for review be applied to their requests for payment.

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